"ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal."

Local No. 2003-158

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

KS 019177

State No.....

ECODE! W75

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED - NAME (First, Middle, Last): (b)(3):CPSA Section 25(c)
2. SEX: Female
3a. TIME OF DEATH: 4:51 AM
3b. DATE OF DEATH (Month, Day, Yr.): June 15, 2003
4. #SOCIAL SECURITY NUMBER: (b)(3):CPSA Sect
5a. AGE - Last Birthday (Years):
5b. UNDER 1 YEAR: Months 2 Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): (b)(6)
7. BIRTHPLACE (City and State or Foreign Country): (b)(6)
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
PLACE OF DEATH (Check only one - See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9a. FACILITY NAME (If not institution, give street and number): Logansport Memorial Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Logansport
9d. COUNTY OF DEATH: CASS
10. MARITAL STATUS (Specify): Never
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): N/A
12b. KIND OF BUSINESS/INDUSTRY: N/A
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Cass
13c. CITY, TOWN OR LOCATION: Young America
13d. STREET AND NUMBER: (b)(6)
13e. ZIP CODE: 46998
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE — American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): (b)(6)
19. MOTHER'S NAME (First, Middle, Maiden Surname): (b)(6)

INFORMANT

20a. INFORMANT'S NAME (Type/Print): (b)(6)
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): (b)(6)
20c. Relationship: GRANDMOTHER

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): America, June 18, 2003 Galveston Cemetery
21c. LOCATION - City or Town, State: Galveston, Indiana
22a. EMBALMER'S NAME: (b)(6)
22b. EMBALMER'S LICENSE NO.: (b)(6)
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Jerry Jackson
24b. LICENSE NUMBER (of Licensee): (b)(6)
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: (b)(6)

CAUSE OF DEATH

26. PART I — Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Suffocation - Accidental — MINUTES
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

PART II — Other significant conditions - Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): n/a
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): Yes
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

CERTIFIER

29a. CERTIFIER (Check only one): ☐ CERTIFYING PHYSICIAN ☐ HEALTH OFFICER ☒ CORONER
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. MEDICAL LICENSE NO.
29d. DATE SIGNED (Month, Day, Yr.)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26 (Type/Print)

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
32. DATE CERTIFIED (Month, Day, Yr.): 6-19-03

32. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☒ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year): 6-15-03
34b. TIME OF INJURY: 2:15
34c. INJURY AT WORK: NO
34d. DESCRIBE HOW INJURY occurred:
34e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State, Zip Code):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (If yes, specify driver, passenger, pedestrian, etc.)